Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN E EARLE MD
PO BOX 33577
SAN ANTONIO TX 78265

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-6770-01

MFDR Date Received
MARCH 9, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Procedure is not included in another. Payment was below the fee schedule."

Amount in Dispute: $5,477.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**DETAILED MDR REVIEW AGAIN SUPPORTS PREVIOUS REVIEWS & PAYMENT AS CORRECT, WITH NO ADDITIONAL REIMBURSEMENT DUE FOR 3/26/2008 SURGICAL PROCEDURES**."

Response Submitted by: Claims Management, Inc., PO Box 1288, Bentonville, AR 72712

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2008	CPT Codes 21899-99, 63075-22, 63076-22, 62291-51, 62291-59, 22554, 22855	$5,477.05	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule adjustment.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 903 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: Endocrine, nervious, eye and ocular adnexa, auditory systems procedure (60000-69999) has been disallowed
- 59 – Charge are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 78 – The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   The requestor billed $550.00 for CPT Code 21899-99, defined and an unlisted procedure of the neck or thorax, on March 26, 2008. According to 28 Texas Administrative Code §134.203(f) for products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) of this title, or the Division, reimbursement shall be provided in accordance with 28 Texas Administrative Code 134.1, relating to medical reimbursement.

   Review of the submitted documentation finds the requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement; nor did the requestor submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support he requested reimbursement for CPT Code 21899-99. The requestor has not supported that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1. Therefore, the amount ordered is $0.00
2. In accordance with 28 Texas Administrative Code §134.203(b)(1) CPT Codes 63076-22 and 63075-22 are not to be reported in conjunction with CPT Code 22554, even if the procedures is performed by separate providers. Therefore, the amount ordered is $0.00.
3. In accordance with 28 Texas Administrative Code §134.203(b)(1) CPT Code 63075 and component CPT Code 62291 are unbundled. The use of an appropriate modifier may be used. The requestor billed this code with modifiers -51 and -59. Review of the operative report documents these procedures were performed at the same site; therefore, the amount ordered is $0.00.
4. In accordance with 28 Texas Administrative Code §134.203(b)(1) CPT Code 22554 and CPT Code 63075 are unbundled. The use of an appropriate modifier may be used; however, now modifier was attached to this code. Therefore, the amount ordered is $0.00.
5. In accordance with 28 Texas Administrative Code §134.203(b)(1) multiple surgery reduction for CPT Code 22855 applies. The maximum allowable for this code is $1,721.46; this amount is reduced by 50% resulting in a reimbursement amount of $860.73. According to the EOB the carrier paid a total of $860.74. As a result, the amount ordered is $0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.